



The Commonwealth of Massachusetts Division of Professional Licensure

Board of Registration of Allied Health Professions

1000 Washington Street, Suite 710, Boston, MA 02118-6100

(617) 727-3071

<http://www.mass.gov/dpl/boards/ah>

INSTRUCTIONS: APPLICATION FOR REINSTATEMENT OF LAPSED/EXPIRED LICENSE

Per board policy as stated in 259 CMR §§2.05 (1)(d) & (2)(d), that the Board may impose as a condition for re-licensure after a licensee has allowed his or her license to expire. Please read and review the Board of Registration of Allied Health Professions ("Board") [Policy Regarding Reinstatement of Lapsed/Expired Licenses](#) prior to completing this reinstatement application.

Continuing Competence:

An individual whose license has lapsed/expired for **(1) year to fewer than five years** is required to demonstrate successful completion of such continuing education/competency:

- Submit all certificates of Completion- **(no less than 1 credit per month for each month that your license has been expired)** and must be from a Board-recognized entity which includes but are not limited to **APTA, FSBPT, AOTA and BOC**. In the event the Board cannot determine proficiency in the profession through successful completion of continuing education/competency credits, then the applicant must retake and pass the appropriate licensing examination.

-OR-

- Copy of current national certification maintained (if applicable).

Please note, individuals whose license has lapsed for **five years or more** are required to retake and pass the appropriate licensing examination. Please contact 617-727-0054 or Alliedhealth@state.ma.us for more information.

The following documents will be required with submission of this reinstatement application:

- Copy of current Resume (all applicants).
- Official (sealed) Certified Statement/Record of standing from each state where you have been employed since your MA license lapsed. **Please request this document directly from the professional licensing agency of each state where you have been employed since your MA license lapsed. Once received, do not open and enclose sealed letter with this application to the Board of Allied Health Professions, 1000 Washington Street, Suite 710, Boston, MA 02118-6100**
- Copy of maintained national certification (if applicable).
- Copies of all or any Continuing Competence certificates for hours being claimed (if applicable).



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APPLICATION FOR THE REINSTATEMENT OF LAPSED/EXPIRED LICENSE

Requirements for reinstatement of a lapsed or an expired license are established in the Board of Registration of Allied Health Profession ("Board") regulations, 259 Code of Massachusetts Regulations (CMR), section 2.05. Please return this two (2) page Application for the Reinstatement of Lapsed/Expired License to the Board of Allied Health Professions, 1000 Washington Street, Suite 710, Boston, MA 02118-6100, with all required documents. **DO NOT MAIL PAYMENT UNTIL BOARD REVIEWS THIS APPLICATION.** Once all materials have been reviewed and approved, the board will notify you that a reinstatement coupon will be mailed to the address noted below for appropriate payment. **Note: It is not legal to practice until this license reinstatement application is approved by the Board.**

Name: _____ Maiden /Other Name(s): _____

Profession: _____ License Number: _____

Mailing Address: _____
Street/Apt. # City, Town State Zip

E-Mail Address: _____ Phone #: H _____ W _____

Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state details (use separate sheet if necessary): _____

Have you ever been convicted of, or admitted to, a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$200.00 was assessed? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary): _____

Have you maintained national certification? (NBCOT or BOC) Yes ☐ No ☐ N/A ☐ **If yes, please include a copy of your current national certification with this application.**

Complete this section if your **license** has **lapsed or expired** AND you **did not** practice in your professional capacity in Massachusetts **OR** any other state.

I attest that I am applying for **reinstatement** of my Massachusetts license to practice as a/an _____.

Further I attest, **UNDER THE PAINS OF PERJURY** that I have not practiced in Massachusetts since my license lapsed on _____, 20____.

Applicant's Signature: _____ Date: _____

On this ____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

(Notary's signature and SEAL)

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Complete this section if your **license** has **lapsed or expired** AND **you have been working** in your professional capacity in Massachusetts.

I attest, **under the pains of perjury**, that I have practiced as a/an _____ and provided services as such from _____ to _____ at (place of employment name and address)

My license AH- _____ - expired on _____, 20_____. During this period, I did not hold a valid license issued by the Board of Registration of Allied Health Professions to practice or provide these services.

Do you currently practice in a jurisdiction that requires Continuing Competence? Yes ☐ No ☐ If yes, please indicate which jurisdiction(s): _____

Applicant's Signature: _____ Date: _____

On this ____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____ (Notary's signature and SEAL)

Note: It is not legal to practice until this license reinstatement application is approved by the Board.

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Complete this section if your license has lapsed and you have been **working in another state**.

I am applying for reinstatement of my Massachusetts license to practice as a/an _____.

I attest, **under the pains of perjury**, that I have not practiced as a/an _____ in the Commonwealth of Massachusetts since my license lapsed on _____, 20_____.

Applicant's Signature: _____ Date: _____

On this ____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____ (Notary's signature and SEAL)

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In some instances, after review of an application, the Board may request additional information or impose additional requirements for reinstatement, including documentation of continuing education, and achievement of a passing score on the licensing examination. (259 CMR 2.05).